THE HOME CARE PROGRAM IN HEALTH UNITS:

A HISTORY OF CHANGE

Prior to 1978

Several health unit home care pilot projects in operation throughout Alberta. Consultation process initiated to develop a coordinated provincial program.

1978

The Coordinated Home Care Program delivered by health units is formally announced in March. Coordinated Home Care Program Regulation is passed effective July 1st. At its inception, the program is limited to people who require health services.

1984

Expansion of the Coordinated Home Care Program to include provision of support services to clients aged 65 years and older, clients requiring palliative care, and physically disabled clients living in designated housing facilities.

1990

Single Point of Entry (SPE) implemented province-wide to provide individuals requiring long term care services in Alberta with a single access point through which their needs are met. SPE ensures that all community options are explored before facility care is considered.

1991

Expansion of the eligibility criteria for the Home Care Program to allow provision of support services to persons under 65 years of age, regardless of their need for professional health services.

2000

New Directions in Community Support

93-02109/

TABLE OF CONTENTS

EXECUTIVE SUMMARY iii

DEFINITION OF HOME CARE iv

A. INTRODUCTION 1

B. CURRENT REALITIES 2
1. THE NEED FOR PARTNERSHIP AND COLLABORATION 2
2. CONSUMER CHOICE 2
3. ALBERTA'S CHANGING POPULATION 3
4. ADVANCING TECHNOLOGIES 4
5. FISCAL CONSTRAINTS 4
6. THE NEED FOR FURTHER DEVELOPMENT OF COMMUNITY CARE 5

C. THE HOME CARE PROGRAM'S STRENGTHS 5
1. CLIENT-CENTRED APPROACH 5
2. FLEXIBILITY 5
3. MULTI-DISCIPLINARY APPROACH 6
4. LOCAL MANAGEMENT 6
5. RESOURCE MANAGEMENT 6
6. KEY INITIATIVES 6
   a. Single Point of Entry (SPE) 6
   b. Broadening the Home Care Mandate for Support Services 7
   c. Self Managed Care 7
   d. Health Unit/Health Facility Partnership 8

D. HOME CARE'S EMERGING ROLE 8
1. HOME CARE FROM THE CONSUMER'S VIEW 8
   a. Seniors 9
   b. Persons with Disabilities 10
   c. Palliative Clients 11
   d. Children with Complex Health Care Needs 12
   e. Persons with AIDS 12
   f. Other Groups with Special Care Needs 13
   g. Support for Families and Caregivers 14
2. HEALTH SYSTEM PRESSURES 14
   a. Acute Care 15
   b. Long Term Care 16
   c. Mental Health 16
   d. Housing 17
   e. Family & Social Services 17

E. NEW DIRECTIONS IN COMMUNITY SUPPORT 18
1. CLIENT-CENTRED CASE COORDINATION - THE HOME CARE DIFFERENCE 18
2. NEW DIRECTIONS: PRIORITIES 19
3. NEW DIRECTIONS: FRAMEWORK 20
a. Enhanced Focus on Consumer Control and Responsibility 21
b. Improved Flexibility and Accessibility 21
c. Enhanced Skill Development and Training 21
d. Improved Standards of Service 21
e. Strengthened Partnerships 22
f. Improved Program Management 22

F. CONCLUSION 23

APPENDICES 25

APPENDIX I **ALBERTA'S HOME CARE PROGRAM: MISSION, VALUES, AND GOALS** 27

APPENDIX II **THE ROLE OF HOME CARE IN ALBERTA** 31

APPENDIX III **HOME CARE PROGRAM ADVISORY COMMITTEE MEMBERSHIP** 33

APPENDIX IV **REFERENCES** 35

EXECUTIVE SUMMARY

This paper outlines the basic issues, both current and anticipated, which will affect the future direction of Home Care in Alberta. The purpose of the document is to generate discussion among interested stakeholders and to gain understanding, support, and agreement about future requirements and the role of Home Care in Alberta.

Alberta's Home Care Program has had a history of change and growth since it was first introduced in health units in 1978. The health system has again entered an important era of change as we attempt to meet the challenges of new social, economic, and political realities. The Home Care Program must be prepared to adapt because it will play a significant role in a reformed health system.

The Home Care Program of today has many strengths which can be built upon to meet future challenges. The program takes a client-centred approach to service, has the capacity to be flexible, involves a mix of service providers who provide a range of services, is available in all localities throughout the province, and has developed skills to manage resources cost-effectively. The challenge for the future is to find ways to build upon these strengths while responding to health system changes which will see much more emphasis placed on meeting people's needs at home.

There are many people for whom the ability to receive care at home is critical to their well-being. Some of these people have been well served in the past, and others have "slipped through the cracks in the system".

To capture the expectations of consumers for Home Care, the concerns and expectations of seniors, persons with disabilities, the terminally ill, parents of children with complex health care needs, persons with specific care needs (AIDS, brain injuries, dementias, etc.), and families and caregivers are outlined. While each group has expectations about the kind of community options which Home Care should facilitate, they share many needs which are common to all consumers.

It is also clear that Home Care plays a major role in easing pressures in the health system. As the health system undergoes reform, Home Care will be expected to assume new and increasingly important roles.

The Home Care Program has emerged as the leading provider of community care in Alberta, and its future will depend primarily on the program's capacity to understand and respond to the diversity of people's needs. If care at home is the preferred option for the future, gaps must be closed, programs must be coordinated and integrated, and a new "seamless" approach to client services must be found.

This paper identifies the expectations of Albertans for service delivery in the home setting, as expressed through their advocacy groups. It also outlines the health system's need for Home Care services from the perspective of the different sectors of health and touches on Home Care's interface with Alberta Family and Social Services programs. It describes the landscape surrounding the provision of care in the home and proposes specific priorities and a framework for change. The priorities have emerged from stakeholders' expectations of Home Care, and the framework indicates how Alberta Health plans to respond.

DEFINITION OF HOME CARE

Home Care is "an array of services which enables clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying, or substituting for long term care or acute care alternatives.

Home Care may be delivered under numerous organizational structures, and similarly numerous funding and client payment mechanisms. It may address needs specifically associated with a medical diagnosis (e.g., diabetes therapy), and/or may compensate for functional deficits in the activities of daily living (e.g., bathing, cleaning, food preparation).

Home Care is a health program, with health broadly defined; to be effective it may have to provide services which in other contexts might be defined as social or educational services (e.g. home maintenance, volunteer visits).

Home Care may be appropriate for people with minor health problems and disabilities, and for those who are acutely ill requiring intensive and sophisticated services and equipment" (Federal/Provincial/ Territorial Working Group on Home Care, *Report on Home Care*, 1990, p. 2).

A. INTRODUCTION

In a sense, home care has come full circle. Prior to World War II, care in the home was the foundation of the health care system, both for short term and long term care. As facility-based care became more available and accepted, the focus on self-care and family care at home lessened, although the need for health and support services in the community remained.

When the Coordinated Home Care Program was introduced in Alberta in 1978, the emphasis was on maintaining elderly persons independently at home if a need for professional health services existed. This original program was modified as a result of pressures from seniors and persons with disabilities. In 1984, the government expanded the program to serve seniors who required only support services. More recently, Alberta Health took a major step toward making Home Care a program for all Albertans requiring community care, regardless of their age or disability. In July, 1991, the program was expanded so persons under 65 years of age could gain access to support services regardless of their need for professional health services.

Alberta's health units have managed the Home Care Program through substantial changes in mandate and resources over the past 14 years. Health units have contributed significantly to Home Care's development. Under health unit management, Home Care has grown to become the largest program in health units and the largest community care program in the health and social service system.

The Home Care Program will continue to grow and expand in the future. The program's broad mission is to "assist Albertans to achieve and maintain health, well-being, and personal independence in their homes". Much has been accomplished, but much remains to be done to provide a full range of independent living options for Albertans. The decade of the nineties will see program adjustments based on the recognition that good health is dependent on factors beyond traditional health care services. The new environment of fiscal pressures has created the momentum for re-examination and change throughout the health system. Many of these changes will involve Home Care, presenting new opportunities for achieving the program's mission.

The need to gain understanding, support, and agreement about the future role of Home Care in Alberta has prompted the development of this document. Effective change can only come from a shared vision of the future direction for Home Care. The ongoing participation of all interested stakeholders in shaping the vision will ensure that the Home Care Program builds on existing strengths and adapts to future requirements.

This document will examine current realities for the health care system, identify emerging challenges, and respond by outlining new directions for Home Care in Alberta.

B. CURRENT REALITIES

The health care system in Alberta is undergoing reform. All sectors are responding to the fact that health is not solely determined by health care services, and to new social, economic, and political realities. These new realities include:

- an enhanced need for partnership and collaboration;
- an increased focus on consumer choice;
- a changing population;
- advancing technologies;
- an environment of fiscal constraint; and
- a need for further development of community care.

Each of these realities affects our perspective on the future role of Home Care.

1. THE NEED FOR PARTNERSHIP AND COLLABORATION

To meet the health and support needs of Albertans in an era of fiscal restraint, Home Care needs to build new and strengthen existing partnerships with other sectors of the health care system and related social service and housing sectors. In today's environment, it is more important than ever that the various sectors of the health system cooperate to use limited resources effectively.

The Home Care Program must provide leadership in establishing effective, client-centred partnerships with other sectors. Neither individuals nor the system can continue to tolerate narrow or territorial approaches to service planning and delivery.

2. CONSUMER CHOICE

Alberta is experiencing a growing consumer rights movement. Consumers are expressing a strong desire to make decisions that affect their personal health and independence and are requesting a range of service options that provide opportunities to maximize participation in the community. This positive trend should be supported through the development of policies and programs which promote and assist individual initiative and responsibility.

The Home Care Program must continue to ensure that informed client choice and decision making are respected and encouraged by fully involving and informing individuals and their families about the options available to address their needs.

3. ALBERTA'S CHANGING POPULATION

One of the major challenges that Alberta faces is the aging of the population. Lower birth rates and increased longevity have contributed to the aging trend. Projections indicate that by the year 2020 the total number of seniors in the 65+ age group will double, and the number of "very old" (those aged 85 and over) will grow at an even faster rate.

Our elderly population is a diverse group with a "wide range of individual differences in the onset and severity of acute and chronic conditions" (McPherson, 1990, p. 175).

Most seniors require very little from our health system; however, there is no doubt that an aging population will result in an increase in the number of individuals with age-related disabilities, acute illnesses, and dementias. Helping more people cope with these limits to independence and their consequences is an important part of Home Care's future.

In the past, women have fulfilled the caregiving role for older Albertans, but as more women enter the paid labour force, fewer are available to provide care on a day-to-day basis. The decreased birth rate and the increased mobility of today's society have resulted in fewer adult children available to provide ongoing personal care. At the same time, the aging population means that those assuming the caregiving role are often elderly spouses and older adult children, who may need assistance with the burden of caregiving.

"The average age of Alberta's population is still the lowest in Canada, but it is also rising" (Alberta Ministry Responsible for Seniors, *Looking to the Future for Seniors #2*, 1992, p. 1). Policies and programs must be developed with this in mind. The Home Care Program will need to balance the cost of providing services to the elderly with the growing number of elderly requiring services. If older Albertans are to maintain their independence, a variety of community long term care alternatives will be required. For example, options need to be developed that combine housing and Home Care services.

4. ADVANCING TECHNOLOGIES

Advancing technologies have had a major impact on the life expectancy of Albertans, especially premature infants, accident survivors, and the elderly. "Medical technology has led to the survival of many persons who may be left with severe impairments that are not well understood or accommodated by the existing service system. It is projected that the costs related to these disabilities will escalate dramatically in subsequent decades" (The Premier's Council on the Status of Persons with Disabilities, *Towards a New Vision of Abilities in Alberta*, 1989, p. 5).

There are increasing pressures from families, advocacy groups, physicians, and hospitals to care for these individuals in the community. Community care programs are serving larger caseloads of young adults with physical disabilities, developmentally delayed or disabled children, persons with AIDS, and people requiring complex care due to earlier discharge from hospital. Advanced technology is also beginning to have a major impact on care provided in the home as medical equipment, life support systems, and technical aids to assist independence become more readily available.

The key ethical decisions regarding the use of advanced technology to prolong life are made by physicians, families and, when able, by individuals themselves. The role of Home Care and other community support programs is to help clients and families live with the consequences of these decisions. There is a clear need for an ethical framework around the use of medical technologies to ensure that people are involved in decisions affecting their lives, and that these decisions are based upon a realistic assessment of the long term human and economic costs and benefits of technological intervention.

5. FISCAL CONSTRAINTS

Alberta's health care costs continue to increase and consume a greater proportion of public revenue. The health system is beginning to address the reality of finite resources. Alberta Health, with the involvement of its partners in the health system, is looking at ways to increase effectiveness and efficiency by developing sound fiscal policies and making better use of existing resources.

As the health and social service sectors have begun to re-examine roles, mandates have been clarified or redefined and service priorities are being implemented. The subsequent shifting of responsibilities and resources has implications for the entire system and for many Albertans.

The Home Care Program of the future must continue to demonstrate that its structure, policies, and comprehensive assessment and case coordination capacities provide it with the framework required to efficiently manage resources, control costs, and provide quality services.

6. THE NEED FOR FURTHER DEVELOPMENT OF COMMUNITY CARE

While it is acknowledged that most people prefer to remain in their own homes, community care options have not yet reached their full potential. In the past, the acute care system focused on high-cost, high-tech care provided in hospitals. Long term care facilities were the focal point for meeting the long term care needs of many individuals. The potential exists to serve more persons with acute and long term care needs in the community.

"Home care expenditures have up to now constituted no more than 2% of the total health budget (publicly funded) in any jurisdiction" (Federal/Provincial/Territorial Working Group on Home Care, *Report on Home Care*, 1990, p. 6). Based on 1992/93 budget allocations, Alberta's Home Care Program received approximately 1.98% of the total provincial health care budget. A focus on facility-based care has created a system which is expensive to maintain, yet does not sufficiently meet the needs of Albertans.

The Home Care Program must continue to develop its leadership role in the coordination and delivery of community-based health and support services. As the pivotal player in the community care system, Home Care is challenged to identify and support innovative, affordable community options. For example, Home Care should promote the development of a range of self-help options (e.g. co-operative housing arrangements) which both empower people and use resources cost-effectively.

C. THE HOME CARE PROGRAM'S STRENGTHS

The Home Care Program in Alberta has many unique features which will equip it to meet the challenges of the future. The program was designed with characteristics which, when combined in a fully developed program, will provide the means to reform the health system on the front lines. However, the Home Care Program is still young, and has not yet reached its full potential. The following section lists some of the major strengths which can be built upon in the future.

1. CLIENT-CENTRED APPROACH

The Home Care Program's philosophy is based on the belief that the primary responsibility for maintaining health and providing care and support lies with individuals and families. Client choice and decision making are supported through joint assessment of needs with individuals who require support to function in the community. Home Care works toward independent living by coordinating the appropriate health and support services which will enhance, but not replace, the care provided by family and friends.

2. FLEXIBILITY

The potential for flexibility is a key strength of Home Care. The program is not limited by large capital investments in buildings and equipment, which can restrict the ability of other sectors to respond quickly to new challenges. As well, the mandate of the program is not rigidly fixed. Change is possible because Home Care is not limited in its capacity for development; the program can be modified to meet newly identified strategic goals, and it can adapt to emerging needs.

3. MULTI-DISCIPLINARY APPROACH

Home Care uses a core of staff which includes nurses, rehabilitation therapists, social workers, personal care aides, and home support aides to meet people's needs. In addition to these core staff, Home Care uses a wide variety of external resources when relevant to the client's needs. The client's physician is involved in planning health services, and some programs retain a consulting physician. In a number of areas, the health unit's Medical Officer of Health fulfils a consultation role. Volunteers play an important role in meeting many client needs, whether organized directly by Home Care or recruited from other community resources. Home Care also helps clients to gain access to specialized services (e.g. speech pathology, early intervention) available within the health unit.

The range of services and the mix of service providers which Home Care can offer or arrange enhances the program's ability to meet a wide variety of client needs.

4. LOCAL MANAGEMENT

Home Care is a locally managed program which provides community-based services to over 19,000 clients per month from 125 offices throughout the 27 health units across the province.[1]

[1] Alberta Health also funds the Twin Rivers Home Care Program to provide services to Alberta residents of Lloydminster.

While Alberta Health sets provincial policies and allocates funds through the health unit system, local Health Unit Boards are responsible for setting local policies and managing services. Local management increases the community's sense of ownership of the program, promotes cost-effectiveness, results in a program that is able to be more responsive to unique local needs, and facilitates the establishment of effective working arrangements with other local service agencies.

5. RESOURCE MANAGEMENT

Home Care's reliance on individual, family, and community assistance in providing care in the home is critical for effective resource management. Through comprehensive assessment and case coordination activities, Home Care staff identify client needs and determine the most appropriate service providers for meeting these needs. These processes combine to produce a strategy which promotes effective resource management. Home Care services are not an "insured benefit" to which all are entitled if a need is identified. The assessment process must establish the need and must also determine that the need cannot reasonably be met by the client or by family and friends. Reliance on the client's informal support network and use of the most effective and economical level of intervention required to meet needs are important strategies for managing community care cost-effectively.

6. KEY INITIATIVES

Several key initiatives recently undertaken in Alberta demonstrate the Home Care Program's response to current realities, its unique role in the health care system, and its evolution.

a. Single Point of Entry (SPE)

The purpose of Single Point of Entry (SPE) is to explore all possible community options before admission to a long term care facility is considered.

The SPE process, developed in cooperation with the long term care facilities sector, provides a single point of access to individuals seeking long term care services in Alberta. Home Care staff conduct assessments; identify needs in cooperation with clients and their families; make recommendations and, if appropriate, provide health and support services that best suit these needs. The rights of clients to be knowledgeable about the long term care options available and to be involved in the decision making process are respected throughout the SPE process.

b. Broadening the Home Care Mandate for Support Services

Home Care has been given a broader role which clearly establishes the program as the provider of acute, long term, and palliative care for all Albertans who require these services at home. The changes to the eligibility criteria implemented in July, 1991, have enabled individuals under the age of 65 to gain access to a broader range of support services. As part of this expansion, a transition strategy has been undertaken for Home Care to provide support services for people who previously received funding from Family and Social Services to purchase care.

c. Self Managed Care

The Self Managed Care option increases individual decision making and control by enabling individuals to manage their own care. Under this option, funds are provided directly to individuals to purchase the support services they require to meet their assessed needs.

Four pilot sites throughout the province are currently testing the provision of a self managed care option within Alberta's Home Care Program. An evaluation will examine the feasibility and effectiveness of the self managed care option and provide recommendations for future province-wide implementation.

Experience gained during the pilot regarding client choice, control, and decision making will be applied to the province-wide implementation of this option.

d. Health Unit/Health Facility Partnership

The goal of the health unit/health facility partnership is to enhance the delivery of community-based acute care services by preventing admissions, enhancing earlier discharge, and improving client quality of life. Projects include Home Parenteral Therapy which provides home-based intravenous and/or subcutaneous infusions, including antibiotic therapy, fluids for hydration, and infusion pumps for pain control.

As part of the health unit/health facility partnership, funds have been provided to Home Care programs to enhance the provision of palliative care services. This initiative supports Alberta Health's policy of providing palliative care at home whenever feasible. The partnership aspect encourages health units and hospitals to cooperate in the planning and delivery of palliative care.

D. HOME CARE'S EMERGING ROLE

Consumers and all sectors of the health care system are placing new expectations on the Home Care Program. The needs voiced by consumers and reflected in health system pressures will shape the future direction of Home Care in Alberta.

1. HOME CARE FROM THE CONSUMER'S VIEW

As the need for better coordination of the various sectors of the health care system increases, consumers will expect Home Care to be the entry point to the community care sector, as well as an important link to facility-based care. Clients often express a need for assistance and guidance in finding their way through the maze of community and facility-based resources available. They will look to front-line programs such as Home Care as the natural source for help in getting the services they need, when and where they are needed. For example, individuals will expect Home Care to ensure that there is a smooth transition from home to hospital to home, from preparation for the hospital admission through discharge planning and the return to independent living.

In the future, Home Care must be prepared to meet the community support needs of all Albertans. Home Care's expanding mandate demonstrates the belief that the program's mission cannot be restricted arbitrarily to certain consumer groups. Each group has expectations about the kind of community options which Home Care should facilitate, but there are many needs which are common to all groups.

Alberta Health must listen to the expressed needs of consumer groups and shape community options and services in ways that can meet those needs. The following section identifies some major consumer groups and attempts, through review of written materials and interviews with key representatives, to identify their expectations about Home Care. The list is not comprehensive, but it does indicate the range of consumer groups and expectations which Home Care faces.

a. Seniors

Seniors have told government that they want to maintain their independence and live in their communities for as long as possible. Through a combination of direct services and coordination of other needed services, Home Care now assists many seniors to remain at home. Home Care's future role will be even more important considering the aging of Alberta's population, the restricted availability of long term care beds, and the shift to reliance on community alternatives.

"We support the need for an expanded Home Care/Community Long Term Care Program - a truly integrated program of home-delivered services. It should have the ability to provide and/or coordinate services for individuals in need. For those for whom a comprehensive assessment is not needed (for example, the need might be for yard maintenance or snow shovelling only), the program should be able to help them find or locate such help" (Seniors Advisory Council for Alberta, *Annual Report 1991-92*, 1992, p. 20).

"The Council recommends the continued expansion of the Home Care Program with an increased emphasis on non-medical support services, such as counselling, homemaker and chore services, and personal care help because an expansion of these services is essential if we are serious about retarding the institutionalization of Alberta's older population" (Seniors Advisory Council for Alberta, *The Future is Now: Alberta's Seniors in the Nineties*, 1990, p. 23).

Seniors have consistently voiced concern that the importance of support services in maintaining older people in the community be sufficiently recognized. Support services, rather than professional health services, often make the difference between a senior remaining at home or entering a long term care facility. Older Albertans want the support services component of the Home Care Program to be enhanced and given a higher profile.

"It appears that we have two separately administered programs providing home-delivered services, the Home Care/Community Long Term Care Program and the municipal FCSS programs. Although we do have a single point of entry, we do not as yet have "one stop shopping" - a place for seniors to call for help in obtaining all home-delivered services ... FCSS programs and health units need to work together to build an integrated, coordinated and accessible community service system" (Seniors Advisory Council for Alberta, *Annual Report 1991-92*, 1992, p. 20).

Seniors have expressed the need for a "one stop shopping" approach to community-based services, and there are expectations that Home Care will be at the core of this model.

Home Care's experience in the development of the Single Point of Entry process to long term care, as well as its coordination activities and its linkages with community and facility-based resources, make the program a natural point of entry to community-based services in general. Older Albertans want to see greater emphasis placed on Home Care's broader coordination role. They see Home Care as a referral and information source for a range of service options, in addition to being a direct service provider.

b. Persons with Disabilities

"Individual choice and corresponding options are increasingly being demanded by consumers. The long range goal of community integration can only be achieved by developing a responsive service system to support those options" (The Premier's Council on the Status of Persons with Disabilities, *Towards a New Vision of Abilities in Alberta*, 1989, p. 5).

Persons with disabilities have expressed their need for programs which incorporate a philosophy of respect for individual rights and choices, acceptance of personal responsibility for risk, consumer participation in service planning, and recognition of the importance of supporting the desire for independence. Persons with disabilities will expect delivery options, like Self Managed Care, which support the principles of independence, personal choice, and participation in decisions about services.

"It is recommended that in order to reduce the need for institutional care beds, it is imperative a long term care program in the community be established to ensure Albertans with physical disabilities presently residing in the community,

with the help of their families, will be allowed to stay in the community" (The Easter Seal Ability Council quoted in *The Rainbow Report Our Vision for Health*, 1989, p. 85).

Persons with disabilities have identified the need for better coordination between programs that provide community-based services. The Home Care Program now provides better integration of personal supports for persons with physical disabilities. Further consolidation will occur as Home Care assumes responsibility for providing professional health services and support services to persons under the age of 65, some of whom previously received funding for these services from Alberta Family & Social Services.

The Home Care Program must be responsive to the needs of persons with disabilities and take a strong leadership role by assisting this client group to live as independently as possible.

"The Action Plan recommended that the Alberta Government establish a new approach to providing personal supports to persons with disabilities by developing a single, consolidated Community Supports Unit" (The Premier's Council on the Status of Persons with Disabilities, *Achieving Full Participation in the Life of Alberta*, 1991, p. 55).

The Premier's Council on the Status of Persons with Disabilities has proposed a "community supports" agency which would bring together the major personal support components for persons with disabilities of all ages in Alberta.

Many of the goals for a community supports unit are similar to the goals for an integrated Home Care Program and some common ground can be found between the two concepts.

c. Palliative Clients

"One of the goals of palliative care is to allow the dying person to remain in the home and community, and to remain functional in society, for as long as possible. Home is the preferred care setting for many dying persons and their families" (Alberta Health, *Palliative Care in Alberta*, 1991, p. 4).

"In the palliative care phase, ... advanced care patients should receive the support it takes to remain at home" (Alberta Cancer Board quoted in *The Rainbow Report Our Vision for Health*, 1989, p. 48).

Individuals in the palliative stage of illness often choose to die in their own homes. Alberta Health supports this action and has placed a priority on the provision of community-based palliative care.

Home Care will be expected to coordinate and provide services to a growing number of palliative clients. Home Care staff need to meet not only the physical needs of palliative clients and their caregivers, but also their psychological and emotional needs. Home Care's coordination role is vital in gaining access to appropriate services which can assist palliative clients and their caregivers in the home.

Clients and their caregivers have identified several barriers which limit effective delivery of palliative care services at home. Medications and equipment provided without charge to the individual in the hospital have been subject to charges in the home. The high cost of pain killers and pain control infusion pumps may deter some individuals from choosing the community option. Technical equipment and daily living aids must be transferred to the home as quickly as possible to ensure continuity of care. Palliative clients need assurances that they can be admitted or re-admitted to hospitals quickly if they experience acute episodes of illness or if their support systems fail.

d. Children with Complex Health Care Needs

Advances in medical technology have contributed to an increased survival rate of children with extensive medical needs. The health and social services systems must find ways to serve children with complex health care needs appropriately and cost-effectively. Children with complex health care needs and their parents need a variety of community care options, ranging from periodic assistance to very extensive care and supervision for the child. Service options are especially needed for those children who may no longer need acute hospital care but whose family needs help in coping with the child's care requirements and the stress of providing continuous care.

"Currently, a number of children with long-term health problems that could be treated in their homes languish in hospitals. This unnecessary situation results primarily from a lack of coordination between service agencies, government departments, hospitals, pediatricians, nurses, social workers and families of these children. Instead of being cared for at home, they remain in hospitals, occupying vital acute care beds (at considerable costs to Alberta taxpayers) for no valid medical reason except for technological dependencies" (Excerpt of a letter to the government of Alberta from Dr. David Berry, Pediatrician, University of Alberta Hospital).

The primary responsibility for assisting families to care for children with complex health care needs now rests with the Home Care Program. As more families decide to care for their children at home, Home Care programs will be expected to find viable community care options for these children whenever possible.

Home Care staff will need to have the skills required to meet the complex care requirements of technology-dependent children. Staff must also be prepared to provide extensive teaching and support for parents in the care of their children.

"Services to children should be provided in a coordinated, holistic manner. Improved inter-departmental coordination will support and improve the coordination and delivery of services in schools and communities" (Alberta Education, *Special Education Review Action Plan*, 1991, p 2).

As increasing numbers of high needs children enter the school system, there will be an increased need for Home Care to coordinate home-delivered services with those required in other settings.

e. Persons with AIDS

"What is needed is a carefully integrated network of care composed of both community-based and institutional services. If persons with AIDS and their loved ones are to receive high quality care, then they must be able to receive what they require, when they require it, in the most appropriate location" (Expert Working Group on Integrated Palliative Care for Persons with AIDS, *Caring Together*, 1989, p. 22).

Persons with AIDS will increasingly look to Home Care for the support they require to remain in the community. The needs of this new client group will present some challenges for Home Care staff. Support systems may be poor or non-existent; caregivers may be infected with the AIDS virus; and clients in the later stages of the illness may have multiple disabilities such as cancer, dementia and/or blindness. Home Care staff must be sensitive to and knowledgeable about the particular needs and circumstances of persons with AIDS.

"We believe AIDS patients and their loved ones require a clearly definable set of palliative care services. These services must be developed and delivered at the community level using a wide range of volunteer and professional caregivers and within an organizational structure which integrates the acute care, long term care, palliative care and community systems into a fully coordinated care delivery system" (Expert Working Group on Integrated Palliative Care for Persons with AIDS, *Caring Together*, 1989, p. 36).

Persons with AIDS rarely experience a gradual decline in health status; rather their status fluctuates and may change quite rapidly. Strong linkages between Home Care and the acute and long term care sectors will be vital for this client group. Home Care may need to facilitate entry, discharge and re-entry to acute and long term care facilities. The type and level of services required from Home Care will also vary as the individual's health status changes. In addition, Home Care's coordination role will be needed to gain access to community-based agencies and services such as AIDS support groups, nutrition counselling, stress management, and psychological counselling.

Because persons with AIDS may have complex care needs, technology will be an integral part of care planning as medical equipment and new drugs become available in the home. With the increased costs involved in this complex care, Home Care will need to consider cost-effective alternatives, such as training non-professionals to provide services.

f. Other Groups with Special Care Needs

Home Care staff encounter people of all ages who have needs which require specialized resources to be addressed properly (e.g. persons with brain injuries, dementias, chronic infectious diseases, etc.). Home Care can address many of the resulting health and support needs of these individuals, but the program must find more effective ways of linking these individuals with specialized rehabilitation and/or treatment services.

Home Care must have the ability to assist in rehabilitation/treatment plans in the home setting when appropriate. To serve these clients effectively, Home Care needs close linkages with geriatric assessment units, rehabilitation centres, mental health services, and any other relevant specialized programs.

"Most consumers (brain injury survivors and their families) were able to identify a variety of services that they would require. The majority of these were caretaking services such as homemaking, meal preparation, house cleaning, etc. People also recognized a need for services that could increase their physical abilities. This included physiotherapy, weight training and access to recreational facilities" (Lefaivre and Hicks, *Residential Services: Issues and Alternatives for Citizens with a Head Injury*, 1990).

g. Support for Families and Caregivers

"Many older people receive help from family and friends. As a first step, it is essential, therefore, to support family and friends in their caregiving" (Seniors Advisory Council for Alberta, *Older People in Alberta: Directions for the Future*, 1987, p. 15).

One of the most important roles that Home Care undertakes is to provide support and respite for the primary caregiver. This support is often crucial in assisting the caregiver to shoulder the burden of care. Most people want to look after their family members but may exhaust themselves trying to keep their spouse, child, or parent in the home. It is important to support the desire to provide care and to encourage caregivers to seek assistance early, so they are better able to cope with their ongoing task.

Caregivers need to be informed about the assistance available to them from Home Care and other community resources.

"When any one person in a family is receiving a service, there is usually an effect on the entire family. It is important, therefore, to consider overall impact of that service on the family when dealing with any member in it" (The Premier's Council in Support of Alberta Families, *Family Policy Grid*, 1992, p. 21).

Because the involvement of informal caregivers is critical to the cost-effectiveness of Home Care, care planning decisions must reflect the needs of family and informal caregivers. Periods of regular or occasional respite are needed so caregivers can attend to their own needs and can get adequate rest. Respite services can ease the burden of continuous caregiving and can assist caregivers to support their family members in the community for longer periods of time. Home Care will be expected to provide more respite in the future. If Home Care is to continue to manage its resources effectively, the program must consider using a variety of service providers with a range of skill levels to meet the needs of clients while giving respite to caregivers.

"Policies and programs must support and strengthen the ability of families to manage and fulfil their own functions including caring for and supporting their own family members. Families need to be empowered by providing them with information, choice and involvement in decision making to facilitate their commitment and responsibility" (The Premier's Council in Support of Alberta Families, *Family Policy Grid*, 1992, p. 22).

Families are caring for greater numbers of individuals in the community who have higher levels of acuity and more complex care requirements. There will be a growing need for Home Care to provide training to both staff and families, so they can manage the technical requirements of the care. Home Care staff have the opportunity to identify an informal caregiver's training needs during the assessment process and have the option of either providing direct training or making referrals to other community learning resources.

Families and caregivers have expressed concern about the availability of back-up services if the individual's support system fails. Strong linkages with other community-based service agencies and the acute and long term care sectors will be crucial in these instances. If families are to be adequately supported in their caregiving, Home Care must establish new and strengthen existing partnerships throughout all sectors of the health and social service system.

2. HEALTH SYSTEM PRESSURES

The future Home Care Program must play a major role in easing pressures on the health system. As the sectors of the health care system undergo profound change, they need a strong and effective Home Care Program to run smoothly. A comprehensive, coordinated community care sector is a fundamental requirement of an effective and efficient health system.

Home Care has emerged as the focal point for the delivery of community-based health and support services in Alberta. The program undertakes four main roles: coordinating community care services, directly providing health and support services, presenting an alternative to institutional care, and serving as a "linchpin connecting the health care sectors together" (Shapiro, 1988, p. 15).

The following section identifies the key service sectors with whom Home Care undertakes its four main roles, as well as pressures each will place on the Home Care Program in the future.

a. Acute Care

The Acute Care Funding Plan currently being implemented in Alberta allocates funds to hospitals on the basis of volume and severity of patient illness. Through funding incentives, the Plan encourages hospitals to decrease average length of stay, to admit people for only the most intense stage of illness, and to promote earlier discharges. These funding incentives have important consequences for the Home Care Program. Home Care will be expected to serve more clients with higher needs as a result of:

- an increase in the number of persons who are referred to community programs, especially Home Care, rather than being admitted to hospital;
- earlier discharge of acutely ill individuals from hospitals, which will result in a need for new Home Care skills and services (e.g. specialized training requirements and 24 hour on-call services);
- earlier discharge of individuals in need of intensive rehabilitation services;
- increased discharge of people with long term care needs who are awaiting admission to long term care facilities; and

- increased requests for Home Care to provide follow-up for persons undergoing surgical procedures at ambulatory care clinics.

There will be a greater need for coordinated pre-admission and discharge planning processes as hospital stays are shortened for acutely ill, short term, long term, and palliative patients. These individuals will need comprehensive, timely discharge planning which eases the transfer from the hospital to the home.

Effective discharge planning needs to be coordinated by staff who have a solid understanding of both the hospital environment and community-based resources. Home Care and hospital staff need to apply an interdisciplinary approach to ensure proper discharge planning. Home Care must ensure that the client and caregivers are prepared to cope with care in the home.

The acute care system needs a Home Care Program with the capacity, flexibility, and resources to meet the pressure for more community care resulting from the Acute Care Funding Plan.

b. Long Term Care

Single Point of Entry (SPE) Process

The single point of entry process is key to achieving the goal of assisting individuals with long term care needs to live at home as long as possible. SPE is based on a partnership between Home Care Programs and long term care facilities. This partnership requires understanding, cooperation, and collaboration. The partners in SPE need to understand the important role each partner plays in the process.

Home Care has been given responsibility to assess the needs of individuals for long term care. Because community-based care is the preferred option for Albertans requiring long term care, it is essential that Home Care do the assessments. As a partner in the SPE process, Home Care ensures that an individual's needs are met in the most appropriate environment. This role carries with it an obligation to develop effective communication strategies. Home Care must build and maintain strong relationships with all other partners in the SPE process.

Long Term Care Beds

The restricted availability of long term care beds resulting from an increase in the aging population and the decreased rate of growth in beds has very significant implications for Home Care. It is clear that Home Care will be expected to meet the needs of persons who might otherwise have been admitted to facilities.

Changes to the long term care facility funding system have reinforced the emphasis on admission of individuals with greater care requirements and have created an incentive to discharge residents with lower care requirements. Through the SPE process, a concerted effort must be made to admit only individuals who cannot be cared for in the community.

The Acute Care Funding Plan for hospitals has also placed new pressures on the long term care system. The Plan promotes the discharge of individuals who have been admitted to acute care facilities while awaiting admission to long term care facilities. The Home Care Program will be expected to meet the high cost, short term needs of individuals who have been discharged to the community until they can be admitted to long term care facilities.

c. Mental Health

The Need for Greater Integration

Isolated planning and delivery systems have created gaps in the accessibility and availability of community-based services for persons with mental illness. Mental health services have been provided through a range of programs from community-based clinics to acute and long term inpatient care. Because of the lack of integration and linkages between the two sectors, Home Care staff have been uncertain when and where to refer clients if mental health problems are identified. A more integrated approach to client services is required to ensure the needs of persons with mental illness are met in the community.

Community Services for Persons with Mental Illness

The Mental Health Division gives preference to community care services that "maintain persons with mental illness in their homes and communities" (Alberta Health, *Future Directions for Mental Health Services in Alberta*, 1992, p. 11).

Home Care must support this goal by cooperating in a coordinated discharge planning process when persons are discharged from mental health facilities. It is especially important to ensure that the client's needs for support in the community are met by Home Care or by other community resources for persons with mental illness.

Home Care must manage the services defined in its mandate in the best interests of this client group, while ensuring that the clients' mental health service needs are addressed through appropriate referrals to community mental health agencies and facilities. As the number of persons with mental illness in the community increases, local Home Care programs must deal with the unique needs of this client group. Multidisciplinary teams with specialized skills, which include mental health staff, will be required.

d. Housing

There is increasing recognition of the importance of coordination and collaboration between health and housing. Public policy that addresses the need for a range of appropriate and affordable housing options for seniors and people with disabilities will go a long way toward assisting people to live in the community.

The range of available options must include those which combine housing, health, and support services. Current options in Alberta that combine housing and health services (including lodges and other congregate settings) need to be examined to ensure that individuals remain in the setting that best promotes their independence and that Home Care services are delivered in an effective and efficient manner.

Home Care will need to work closely with housing sectors to encourage innovative housing options and to enhance existing options that combine housing, health, and support services. An appropriate combination of housing and services will enable many people with functional limitations to remain in the community and maintain their independence.

e. Family & Social Services

Supports For Independence and Handicapped Children's Services

Alberta Family and Social Services is undergoing some major changes resulting from fiscal restraint and the clarification of its mandate. Some of these changes have important immediate and long-term implications for Home Care.

Prior to 1992, Family and Social Services provided funds to meet health and support service needs for anyone who qualified for Social Allowance (now called Supports for Independence or SFI). During the last year, the Ministers of the two departments reached an agreement which will result in Home Care addressing the community health and support services needs of most persons with physical disabilities by 1994. Family and Social Services retains responsibility for the provision of support services to persons with mental disabilities.

Aside from the obvious effects of these changes upon the Home Care budget and caseload, Home Care must adapt to a new client group with a history of managing funds rather than receiving services directly. The development of Self Managed Care within Home Care provides clients with a significant new option which should help ease the transition.

With Home Care's involvement, Family & Social Services is continuing to review its role in other programs which provide funding for personal support services.

Home Care has already assumed responsibility for serving the health and related personal care needs of children with complex health care needs (formerly funded through Handicapped Children's Services), and there will be more discussions about mandates over the next few years.

Family & Community Support Services (FCSS)

In many areas of Alberta, municipal FCSS Programs or their funded agencies have been providing home support services. Some elements of these support services may be provided under contract to Home Care, while other elements (e.g. home maintenance and "handyman" services) are funded directly by FCSS agencies to meet the "lighter" care needs of individuals.

The division of responsibilities between Home Care and FCSS agencies varies greatly across the province. The Seniors' Advisory Council has noted that people may have difficulty understanding which community agency or organization delivers the kind of services that are needed by individuals.

Changes in the provincial mandate for either program may have very important consequences for the relationship between Home Care and FCSS at the community level. Home Care's gradual shift to serving persons with higher needs has resulted in new demands on local FCSS agencies. Similarly, decisions by local FCSS Programs to shift their program priorities may result in reduced funds for home support and increased demands on Home Care.

Ongoing discussions between FCSS and Home Care at the provincial and community level is vital to help determine gaps in the delivery of home support services and to develop coordinated strategies to address these needs.

E. NEW DIRECTIONS IN COMMUNITY SUPPORT

In its short history, the Home Care Program has emerged as the leading provider of community care in Alberta. The limits of the future Home Care role, both in terms of the diversity of consumers served and the range of needs which the program might address, are not defined. Instead the limits will depend upon Home Care's capacity to respond to the needs and expectations of consumers, and its capacity to improve the cost-effectiveness of the health system.

Home Care is now a mainstream program; it has shed its image of a peripheral program which was an add-on to the "real business" of funding facilities, doctors, and drugs. The recognition of the value and potential role of community options (from both the consumer's and the system's perspective) leads directly to Home Care, and Alberta Health is developing the kind program needed to meet the challenge. In addition to taking on an essential role in the management of long term care resources through the single entry process, Home Care now provides new community options for persons with disabilities and persons with acute or palliative care needs.

The vision for Home Care must be driven by its mission to assist clients to find whatever supports are available and appropriate to promote client independence. In the client's interest, the vision must be broad. Home Care staff must be aware of and knowledgeable about the range of resources and options which are available for clients. The process of acting on this awareness, in partnership with the client and other service sectors, is called ***case coordination***.

Case coordination is one of Home Care's most important functions, it is the reason for Home Care's growth, and it is the foundation for the future development of client-centred community options.

1. CLIENT-CENTRED CASE COORDINATION - THE HOME CARE DIFFERENCE

Everyone is interested in developing a service system which provides the right services to the right persons in the most cost-effective manner. This has proved to be an elusive goal, and it will remain elusive unless we find better ways to coordinate services between sectors in the interest of those needing assistance. Coordination will be effective if it is driven by the needs of clients, and if the coordinating program has strong links to the other sectors.

The need for a program to coordinate services in the interests of the client has been expressed in a variety of ways. Home Care is often seen as the vehicle for coordination:

- During a speech to the Health Unit Association of Alberta in April, 1992, Health Minister Nancy Betkowski described Home Care as the "oil" which makes the system run smoothly for persons needing assistance.

- The Seniors Advisory Council has recommended that Home Care serve as the route for "one-stop shopping" to help seniors find the services that will meet their needs.

- Discussions with representatives of the acute care sector suggest an emerging need for a coordinated acute care approach which provides a "seamless" system for consumers from home to hospital to home.

- The Premier's Council on the Status of Persons with Disabilities has consistently supported the concept of a "community supports" agency. The underlying issue which the Council has so clearly identified is the need to find ways to assist individuals with the confusing maze of programs and services which they face.

Home Care cannot take direct responsibility for all the supports that people need, but it can provide the linkages to ensure that people do not "fall through the cracks" in the system. Through its comprehensive assessment and case coordination capacities, Home Care has the ability to identify needs and assist individuals to find the most appropriate resources, whether the needs are best served by families, friends, Home Care, other community agencies or self-help groups, physicians and other independent health care professionals, or by acute or long term care facilities.

This approach requires the continuing development of effective working relationships with hospitals, long term care facilities, independent service providers, and related programs in the health, social services, education, and housing sectors.

In Alberta, the Home Care Program has already assumed a very significant coordination role for long term care services. Home Care's role in the development of the single point of entry for long term care demonstrates what can be accomplished using a community-based, client-centred approach to coordinating service options.

The same approach could be used for persons requiring other kinds of services, including "assisted living" housing and acute care services.

The development of Home Care's "linchpin" role is not restricted to Alberta. The national Report of the Working Group on Home Care clearly identified the broad coordination role that is emerging for Home Care as it develops close working relationships with other sectors to ensure that the right services are provided to clients. Home Care's coordination role works because it links the system and the people that need the services together. All new directions proposed in this document (such as enhancing services to a particular target group or filling a gap in the system) must be understood within the essential context of case coordination.

2. NEW DIRECTIONS: PRIORITIES

During the next few years, Home Care must place priority on addressing the following key client needs in partnership with other sectors:

- Meeting people's need for assistance in understanding, selecting, and obtaining the right services and independent living options, including institutional options when appropriate;

- Enhancing the client-centred approach to service delivery by integrating the principles proposed by the Premier's Council on the Status of Persons with Disabilities;

- Completing the transfer of responsibility for meeting the health and support needs of persons with physical disabilities from Family and Social Services to Home Care;

- Working in partnership with hospitals to expand current services in the community for persons with acute care needs;

- Developing resources to assist families of children with complex health care needs to care for their children at home;

- Enhancing respite options and other supports for families who are providing care which is essential for clients to remain in the community;

- Participating in the creation of new community housing options which combine independent living with good access to community support services;

- Improving the program's capacity to meet the needs of persons with mental illness by arranging the right combination of therapeutic and support services; and

- Expanding the availability of palliative care services and community support for persons with AIDS.

3. NEW DIRECTIONS: FRAMEWORK

Home Care must evolve as a program focused on its mission to "assist Albertans to achieve and maintain health, well-being, and personal independence in their homes". This mission can only be achieved if Home Care performs its case coordination and service delivery roles effectively.

Home Care will be able to meet the expectations of consumers and the service system if the program has both the strength to fully address client needs and the flexibility to adapt to changing realities and priorities. To meet current and future community support needs as expressed by consumers and other service sectors, a framework for future development is proposed which is founded on the following key components:

- *Enhanced Focus on Consumer Control and Responsibility*

- *Improved Flexibility and Accessibility for Clients*

- *Enhanced Skill Development and Training for Home Care Staff*

- *Improved Standards of Service for Home Care Programs*

- *Strengthened Partnerships with Other Service Sectors*

- *Improved Program Management and Accountability within Home Care Programs*

a. Enhanced Focus on Consumer Control and Responsibility

- Use the statement of Home Care's mission, values, and philosophy to drive care planning, priority setting, and decision-making.
- Encourage greater participation of clients and their families through policy innovations which reinforce consumer control and responsibility, e.g. Self Managed Care.
- Emphasize self-care and the importance of informal support.
- Develop an ethical framework for the Home Care Program which promotes client choice and responsibility, including the right to risk, and integrate the framework into the assessment and service planning process.

b. Improved Flexibility and Accessibility

- Increase the accessibility of the Home Care Program through flexible service provision, e.g. 24 hour availability of services when required.
- Improve program responsiveness to client groups and new needs, e.g. persons with AIDS, children with complex health care needs.
- Assume greater responsibility for ensuring that clients referred to Home Care gain access to all the services they need through information and referral, including those not provided by Home Care (e.g. the "one-stop shopping" approach advocated by the Seniors Advisory Council).
- Promote the full integration of the support services component within Home Care.
- Develop strategies for delegation of tasks (transfer of function) which will allow more flexibility in arranging services cost-effectively.

c. Enhanced Skill Development and Training

- Strengthen the interdisciplinary approach to assessment and care planning to ensure that client needs are being met.
- Improve the skill development and training of Home Care staff, particularly for staff providing personal support services and for staff meeting complex needs, such as acute and palliative care.

d. Improved Standards of Service

- Develop strategies to deal with recruitment, retention, and remuneration issues for staff in the Home Care Program to ensure quality and continuity of service to clients.
- Enhance the involvement of volunteers in the Home Care Program.

- Support the continuing development and implementation of program standards for Home Care.

e. Strengthened Partnerships

- Use Single Point of Entry for long term care as a model for coordination of all services to meet client needs, thus ensuring a smooth transition between sectors for clients, and elimination of gaps in services.

- Cooperate in the development and implementation of a coordinated discharge planning process for persons in acute care, long term care, or mental health facilities.

- Develop strategies, in cooperation with appropriate partners, to transfer specialized technology, equipment, and aids from facilities to the community.

- Promote coordinated public policy on services and benefits which will make partnerships more effective (e.g. removal of economic disincentives to choosing community care options).

f. Improved Program Management and Accountability

- Establish policy and fiscal incentives which reflect the mission, values, and philosophy of the Home Care Program.

- Enhance the capability of the Home Care Program to establish priorities and allocate resources fairly and responsibly.

- Ensure the Home Care Program has the organization and staffing required to meet the broad spectrum of client needs.

- Implement quality improvement strategies to ensure that the program is client focused and meets its goals in a cost-effective manner.

- Broaden and strengthen the Home Care Program's support and commitment for new accountability measures.

F. CONCLUSION

The "New Directions Priorities" have emerged from the stakeholder expectations of Home Care, changes in the social services sector, and the fundamental rebuilding now occurring within the health system through the role statement process.

The "New Directions Framework" indicates how Alberta Health plans to respond to the needs and expectations of consumers and to system pressures. Each new direction will require more specific strategies which will be developed after consumers and other service sectors have had an opportunity to review and comment upon the document. Taken together, the directions will lead to a Home Care Program which addresses community support needs with clients in a cooperative, flexible, and responsible manner.

APPENDICES

I ALBERTA'S HOME CARE PROGRAM: MISSION, VALUES, AND GOALS

II HOME CARE IN ALBERTA: IDENTIFIED ROLES

III HOME CARE PROGRAM ADVISORY COMMITTEE MEMBERSHIP

IV REFERENCES

APPENDIX I ALBERTA'S HOME CARE PROGRAM: MISSION, VALUES, AND GOALS

MISSION:

The mission of the Alberta Home Care Program is to assist Albertans to achieve and maintain health, well-being, and personal independence in their homes.

VALUES AND BELIEFS:

1. Albertans want and need to be as independent as possible and want to receive assistance within the family and community environment whenever possible.

2. The primary responsibility for care lies with the individual.

3. Support provided by family and community is essential in the provision of community care alternatives.

4. The autonomy and dignity of individuals should be respected; clients have the right to participate in decisions, based upon full and accurate information, including the right to:

   - accept or refuse offered services;
   - exercise a significant degree of control over service arrangements;
   - risk personal health and/or safety to retain independence; and
   - appeal care decisions and to have the appeal handled promptly.

5. Clients should contribute to the cost of services, but the ability to pay should not deter anyone from seeking Home Care services.

6. The Home Care Program is an essential component of the health and social service system and must coordinate its services with other human service sectors.

7. Home Care programs are most effectively managed at the local level where there is a greater awareness of the needs and resources of clients, families, and communities.

GOALS:

1. Assist clients to live in the community by providing assessed health and support services at home, preserving the support provided by family and community whenever possible.

   Strategies to Achieve the Goal:

   a. Provide clients with a consistent, comprehensive, and client-centred assessment of need, using an inter-disciplinary approach to assessment and service planning.

   b. Provide the lowest level of intervention required to meet the client's assessed needs.

   c. Teach clients and/or families to care for themselves rather than providing services directly.

   d. Coordinate services required by all Home Care clients, including assisting clients to gain access to related services to meet identified needs.

   e. Create links with volunteers and volunteer agencies in the community, and maximize the use of volunteers in meeting client needs.

   f. Provide a single access point for individuals seeking long term care services, through which client needs and available services are matched to ensure selection of the most appropriate long term care option for the client.

   g. Develop and implement methods to determine the relative priority of client needs based on assisting persons who are at the highest risk of losing their choice to live in the community.

   h. Develop, monitor, and revise standards of care on an ongoing basis to ensure that Home Care clients will receive quality services.

   i. Integrate health promotion goals and practices in the preparation of service plans and the provision of Home Care services.

2. Work with other providers in the health and social service sectors to increase the effectiveness of Home Care and to eliminate service gaps and duplications.

   Strategies to Achieve the Goal:

   a. Promote more efficient use of acute care resources by working with the hospital sector to prevent unnecessary admissions and to facilitate earlier discharge.

   b. Promote more efficient use of long term care resources by working with the long term care and housing sectors to assist persons to gain access to the most effective and appropriate services.

c. Develop effective working arrangements with the mental health and social service sectors to eliminate duplication of services and to improve the client's ability to gain access to needed services.

3. Manage services efficiently and demonstrate accountability for the effective use of public funds.

Strategies to Achieve the Goal:

a. Clarify the respective roles and responsibilities of Alberta Health and agencies funded to provide home care services by establishing funding and service policies which define the relationship.

b. Develop the capacity to evaluate program effectiveness by capturing information which will assist in the measurement of program outputs and outcomes.

APPENDIX II THE ROLE OF HOME CARE IN ALBERTA

- Information and program referrals for Albertans seeking community support services, linking health, housing, and social services programs and sectors to meet client needs.

- Assessment and case coordination services for clients of all ages meeting Home Care eligibility criteria.

- Development, with the client, of cost-effective service plans which:

  - cover the full range of assessed needs
  - emphasize self-care and the independence of the client
  - recognize the need to maintain informal support;

- Provision/arrangement of training for clients and informal caregivers.

- Provision/arrangement of mandated professional health services and home support services to clients at home, in lodges, and in other community settings, for the following purposes:

  - client achievement of optimal health, well-being, and personal independence
  - community-based palliative care services
  - respite which supports and encourages informal supporters
  - community options for children with complex health care needs
  - community options for persons with acute care needs
  - community options for Albertans of any age with long term care needs

- Responsibility for determining appropriate long term care services:

  - assessment and case coordination for all persons seeking long term care services
  - identification of viable community options for the client
  - referral to placement committees/agencies for admission to long term care facilities whenever appropriate
  - facilitating discharge from long term care facilities to the community whenever possible
  - building and maintaining strong relationships with all other partners in Alberta's long term care system

- Responsibility for developing effective community-based acute care options:
    - providing acute care services which avoid in-patient stays or reduce re-admissions
    - working with hospital staff to coordinate hospital/home care discharge planning
    - pre-admission and in-hospital assessment and case coordination
    - facilitating discharge through timely arrangement of required services/equipment upon discharge to any location in Alberta

APPENDIX III HOME CARE PROGRAM ADVISORY COMMITTEE MEMBERSHIP

Lois Borden (Chairperson), Director, Home Care/Community Long Term Care Branch, Alberta Health
Jean Fraser, Health Unit Association of Alberta
Dr. Richard Cherry, Seniors Advisory Council
Dr. Fran Vargo, The Premier's Council on the Status of Persons with Disabilities
Joyce Baird, Alberta Healthcare Association
Herb Flieger, Family & Community Support Services Association of Alberta
John King, Consumer
Brenda Moore, Consumer
Dr. Brent Friesen, Medical Officer of Health, Calgary Health Services
Dr. Hilary Wynters, Medical Officer of Health, South Peace Health Unit
Mary McCabe, Home Care Director, Edmonton Board of Health
Ruby Manning, Department Head Continuing Care, Fort McMurray & District Health Unit
Lennie Kerr, Home Care Manager, Southeastern Alberta Health Unit
Vivien Lai, Executive Director, Long Term Care Branch, Alberta Health
Denis Ostercamp, Executive Director, Mental Health Division, Alberta Health
Evelyn Swanson, Assistant Director, Research and Planning Branch, Alberta Health
Kurt Hall, Manager, Home Care/Community Long Term Care Branch, Alberta Health
Pat Inglis, Manager, Home Care/Community Long Term Care Branch, Alberta Health
Fern Miller (Secretariat), Community Care Planner, Home Care/Community Long Term Care Branch, Alberta Health

APPENDIX IV REFERENCES

Alberta Education. (1991) *Special Education Review Action Plan*, Edmonton.

Alberta Government. (1991) *Partners in Health: The Government of Alberta's Response to the Premier's Commission on Future Health Care For Albertans*, Edmonton.

Alberta Government. (1988) *Caring & Responsibility - A Statement of Social Policy for Alberta*, Edmonton.

Alberta Health. (1991) *Palliative Care in Alberta* (Draft), Edmonton.

Alberta Health. (1992) *Future Directions for Mental Health Services in Alberta*, Edmonton.

Alberta Health Facilities Review Committee. (1990) *Foundations for the Future: The 1990 Senior Citizens' Lodge Survey*, Edmonton.

Alberta Ministry Responsible for Seniors. (1992) *Looking to the Future for Seniors*, Edmonton.

Berry, Dr. David. (1992) Letter Prepared for a Meeting Between Alberta Health and Consumer Advocates and Service Delivery Representatives Concerning Home Care for the Technology Dependent Child, March 30.

Canadian Long Term Care Association. (1990) *Choices: Long Term Care in the 90's, Conference Proceedings and Models for Collaboration*, Ottawa.

The Canadian Medical Association. (1987) *Health Care for the Elderly: Today's Challenges, Tomorrow's Options*, Report of the CMA Committee on the Health Care of the Elderly, Ottawa.

Health and Welfare Canada. (1989) *Caring Together*, Report of the Expert Working Group on Integrated Palliative Care for Persons with AIDS, Ottawa.

Health and Welfare Canada. (1990) *Report on Home Care*, Federal/Provincial/Territorial Committee on Long Term Care, Ottawa.

Lefaivre, D. and Hicks, J. (1990) *Residential Services: Issues and Alternatives for Citizens with a Head Injury*, Prepared for the Head Injured Relearning Society, Calgary.

McPherson, Barry D. (1990) *Aging as a Social Process: An Introduction to Individual and Population Aging*, Toronto: Butterworths.

Novak, Mark. (1988) *Aging and Society: A Canadian Perspective*, Scarborough: Nelson Canada.

The Premier's Commission on Future Health Care For Albertans. (1989) *The Rainbow Report Our Vision for Health*, Edmonton.

The Premier's Council in Support of Alberta Families. (1992) *Family Policy Grid*, Edmonton.

The Premier's Council on the Status of Persons with Disabilities. (1991) *Achieving Full Participation in the Life of Alberta*, Edmonton.

The Premier's Council on the Status of Persons with Disabilities. (1990) *Action Plan*, Edmonton.

The Premier's Council on the Status of Persons with Disabilities. (1989) *Towards a New Vision of Abilities in Alberta*, Edmonton.

Seniors Advisory Council for Alberta. (1987) *Older People in Alberta: Directions for the Future*, Edmonton.

Seniors Advisory Council for Alberta. (1990) *The Future is Now: Alberta's Seniors in the Nineties*, Edmonton.

Seniors Advisory Council for Alberta. (1992) *Annual Report 1991-92*, Edmonton.

Shapiro, Evelyn. (1988) Address to the Federal/Provincial/Territorial Committee on Continuing Care, September 15.